



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448
Anoka County

Report #: H5353028

Date: June 23, 2006

Date of Visit: 5/17/06
Time of Visit: 8:00 a.m.

By: Jaime Hujanen, R.N.
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of neglect in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minnesota Statute 626.557.

The allegation is: On 4/9/06 resident #1 was taken to the bathroom to be toileted. The Nursing Assistant left her unattended and the resident attempted to get up and fell resulting in a broken neck. She was sent to the hospital and was in the ICU for a few days and returned to the facility on approximately 4/13/06. They could not do surgery. Her neck was put into a brace. She developed pneumonia and died on 4/29/06. The fall was the result of neglect.

Investigative Findings:

All employees and persons were interviewed in private as desired and given the Tennessee Statement.

The investigation included a review of the following: resident #1's medical record, including pertinent portions of her hospital medical record; staff schedules and assignments for April 6, 2006 through April 9, 2006; incident/accident reports and fall logs for March 2006 through May 2006; Nursing Assistant assignment sheets; policies and procedures in regards to falls and safety devices; personnel files, including orientation, training and job descriptions. Observations were completed in addition to interviews with residents and facility staff. Additional resident medical records were reviewed in regards to falls and interventions provided by staff. The complainant was interviewed in regard to the allegation.

Resident #1's medical record was reviewed and revealed the following: resident #1 was admitted to the facility on 4/29/05. She had diagnoses including: dementia, ataxia and cervical spondylosis (arthritis of the neck) with chronic back and neck pain. According to her care plan and documentation in her medical record she was alert and oriented, required the assistance of one staff with her activities of daily living and the assistance of two staff with her mobility needs. She was at risk for falls secondary to a

history of several falls at the facility, use of psychotropic medications (which may increase the risk of falls), and impaired mobility (she required assistance of one staff member with all transfers and only ambulated with physical therapy). The care plan indicated that a TABs alarm (a device to alert staff when a resident attempts to transfer without assistance) was initiated on 6/28/05 and it was discontinued on 9/27/05. However, there was no documentation found in the chart indicating why the TABs alarm was discontinued. In addition, no assessments or evaluations were found to determine resident #1's safety after the discontinuation of the safety device. The Nursing Assistant assignment sheets for resident #1 did not identify resident #1 as a fall risk. A facility Falls/Risk Assessment, dated 3/10/06 and completed by employee (H), indicated that resident #1 was at risk for falls.

The facility's incident reports for resident #1 from 6/4/05 through 4/9/06 were reviewed and indicated the following:

- On 6/4/05, at 6:15 p.m., she had a fall in the bathroom when she attempted to transfer herself from her wheelchair to the toilet.
- On 6/26/05, at 6:05 p.m., she was found on the floor of her room when she was "trying to get into bed" from her wheelchair. The facility staff initiated a TABs alarm when in her wheelchair for safety.
- On 10/3/05, at 7:25 a.m., resident #1 was found between the toilet and her wheelchair in the bathroom. She stated, "I fell off of the toilet...my feet went numb." She sustained a five-millimeter skin tear to her right forearm. The staff stated that it appeared that the resident "was attempting to self transfer." The facility's "Action Plan," completed by employee (H) indicated that resident #1 needed an alarm for her wheelchair. The documentation further indicated that the staff had just removed the TABs alarm "per (resident #1's) request...(resident #1) did not make any attempt to self-transfer." The documentation indicated that resident #1 did not want the TABs alarm and refused the idea of hip protectors. Resident #1 indicated to staff that her fall was isolated and "she thinks she fell asleep on the toilet."
- On 12/16/05, at 8:30 p.m., she was found in the bathroom and stated, "(I) was trying to position myself on the toilet and lost my balance, then I fell against my chair."
- On 4/9/06, a facility incident report and correlating nursing note for resident #1, beginning at 9:45 a.m. and completed by employee (C)/nurse and employee (A)/administrative staff, documented that employee (B)/NAR had taken resident #1 to the bathroom and advised the resident to use the call light when she finished. Resident #1's wheelchair was in the bathroom to her left. While the resident was in the bathroom, employee (B) went across the hall to make another resident's bed. When employee (B) finished, she noticed that resident #1's call light was on. Upon entering resident #1's room, she heard a "crash" and entered the bathroom to find resident #1 "on (the) floor, head down, buttocks up in (the) air...It appears that (resident #1) had possibly attempted to pull (up) own pants (before) staff got there". She sustained 3" purple bruises to both of her knees, a 3" by 3 1/2" raised hematoma to her forehead and neck pain. The on-call Nurse Practitioner was notified and resident #1 was sent to the hospital for further evaluation.

The hospital records, dated 4/9/06 through 4/12/06, documented that resident #1 had a CT scan (Computed Tomography used to detect abnormalities including fractures and abnormalities in the neck and spine) that revealed a C2, non-displaced but complex cervical (neck) fracture, mild acute compression fractures to T3 and T4 (her upper spine) and closed head trauma. Resident #1 indicated to the hospital staff that "her legs fell asleep on the toilet and she tried to get up." She was treated with an external orthosis (a neck brace) and was discharged back to the facility on 4/12/06. She subsequently developed pneumonia and expired on 4/29/06.

Employee (B) was interviewed on 5/17/06 at 11:25 a.m. and stated the following:

- She was one of resident #1's primary NARs and cared for her two to three times a week. Resident #1 required the assistance of one to two staff (depending on her pain) with transfers, however, she did attempt to "self transfer...off of the toilet" approximately once a week.
- Resident #1 had a TABs alarm last year (unknown date), however, resident #1's family member requested to have the TABs alarm removed.
- She verified the information in resident #1's incident report and documentation from 4/9/06.
- The policy at the facility is that if a resident has a TABs alarm, the staff cannot leave the resident alone in the bathroom. However, since resident #1's TABs alarm was discontinued she could be left alone and did not have to be supervised in the bathroom.

Employee (C) was interviewed on 5/17/06 at 11:45 a.m. and stated the following:

- She was familiar with resident #1. Resident #1 required the assistance of one staff. She would transfer herself or "threaten" to transfer herself approximately once a week. Resident #1 used to have a TABs alarm, but it was removed because the family wanted it off. If a resident does not have a TABs alarm, there is no need for staff to supervise them in the bathroom.
- She verified the information in resident #1's incident report and documentation from 4/9/06.
- She indicated that on 4/9/06, it appeared that resident #1 tried to transfer herself and she fell forward.

Employee (D)/NAR was interviewed on 5/17/06 at 12:00 p.m. and stated the following:

- She cared for resident #1 once or twice a week.
- She stated that resident #1's TABs alarm was discontinued (on unknown date for unknown reason). However, she would still attempt to transfer herself without staff assistance "in the bathroom" approximately once a week. After resident #1's TABs alarm was discontinued, it was "no longer a requirement" to supervise her in the bathroom.

Employee (A) was interviewed on 5/17/06 at 10:35 a.m. and stated the following:

- She verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that she did not have a concern regarding the fall because the care plan and policy had been followed.
- Resident #1 did have a TABs alarm in the past due to attempts to transfer without staff assistance and a history of falls. The family requested that the TABs alarm be removed because it "agitated" resident #1. After resident #1's TABs alarm was discontinued, it was no longer a requirement that the staff supervise her in the bathroom.
- She was unsure if resident #1 continued to attempt self-transfers after the TABs alarm was discontinued. No other interventions were put into place after the TABs alarm was discontinued.

Employee (H)/administrative staff was interviewed on 5/24/06 at 3:00 p.m. and stated the following:

- She was familiar with resident #1 and indicated that resident #1 was "impulsive" and would "intermittently" transfer her self without staff assistance.
- Resident #1 used to have a TABs alarm and required staff supervision in the bathroom. During a care conference in September 2005, the TABs alarm was discontinued per family request. She indicated that she documented this conversation, but was unable to locate or provide the documentation.

- No assessments or evaluations were done after resident #1's TABs alarm was discontinued to evaluate resident #1's safety. Resident #1 continued to attempt to transfer herself without staff assistance and the facility staff did not provide any further interventions.
- According to the facility policy, resident #1 no longer required supervision in the bathroom, because her TABs alarm had been discontinued.

Nurse Practitioner (G) was interviewed on 6/5/06 at 1:16 p.m. and stated the following:

- Resident #1 was alert and oriented, however her "judgment definitely was impaired."
- When a resident is at risk for falls, the facility should put all the measures in place to reduce that risk. If a patient or family does not want a TABs alarm, we can honor that, but the facility needs to have a plan in motion. Supervision in the bathroom was "clearly a need for this patient... even though she did not want the TABs alarm, there needed to be some intervention in place to prevent falls other than just the TABs." She needed to be supervised in the bathroom and that should have been part of her care plan.
- This fall and the resulting injuries were part of "a chain of events that resulted in her demise."

Conclusion: As defined by federal regulatory requirements at 42 CFR 483.13 (c), and the current statutory definition of neglect specified in Minnesota statute 626.5572, **neglect of health care did occur** in connection with the allegation that resident #1's fall was the result of neglect. Interviews and documentation review established the following:

- The facility was aware that resident #1 was at a high risk for falls due to her history of falls, impaired mobility, psychotropic medication use and unsafe attempts to transfer herself in her room and bathroom without staff assistance.
- The TABs alarm was discontinued per family request, but resident #1 was not evaluated or assessed after the removal of the alarm, nor were interventions implemented to deal with her high risk of falls.
- Although the facility was aware of resident #1's fall risk, they failed to provide supervision, assistance and on-going interventions to reduce resident #1's risk. On 4/9/06 resident #1 was left unsupervised and alone in the bathroom. She sustained a fall, which resulted in a non-displaced but complex cervical fracture, mild acute compression fractures to T3 and T4 (her upper spine) and a head injury. She subsequently developed pneumonia and expired on 4/29/06.

During the course of the investigation, problems were identified regarding the facility's failure to comply with regulatory requirements in regard to identifying residents at risk for falls and providing supervision, assistance and on-going interventions to prevent or reduce the risk of accidents and/or falls. As a result, the following federal deficiency is issued: 42 CFR 483.25 (h)(2)/tag F324. In addition, the following state licensing order is issued: 4658.0520 Subpart 1.

The "mitigating factors" in Minnesota Statute 626.557, Subdivision 9c (c) were considered and it was determined that the facility is responsible for the neglect. The facility will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

xc: Division of Compliance Monitoring - Licensing & Certification
Board of Nursing
Board of Nursing Home Administrators
Coon Rapids City Police Department
Anoka County Attorney
Coon Rapids City Attorney



Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:

Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448
Anoka County

Report #: H5353028

Date: July 6, 2006

Date of Visit: July 6, 2006

Time of Visit: 4:30p.m.

By: Jaime Hujanen, R.N.
Special Investigator

Nature of Visit

An unannounced visit was made in order to follow-up one federal deficiency and one state licensing order which were issued on May 26, 2006, as the result of an investigation which had been completed on May 25, 2006.

The status of the order is as follow:

1. MN Rule 4658.0520 Subpart 1. - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

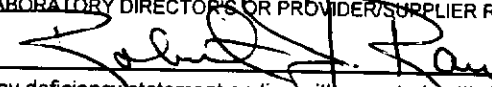
Printed: 05/25/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2006
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NAME OF PROVIDER OR SUPPLIER CAMILIA ROSE CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11800 XEON BOULEVARD COON RAPIDS, MN 55448
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard abbreviated survey was conducted to investigate #H5353028. The following deficiency is issued:	F 000		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on interviews and documentation review the facility failed to ensure that supervision, assistance and on-going interventions were provided for one of one resident (resident #1) who was identified to be at risk for falls. Findings include: Although the facility was aware that resident #1 was at risk for falls due to her unsafe attempts to transfer herself without staff assistance in her room and in her bathroom, history of falls, impaired mobility and psychotropic medication use (which may increase the risk of falls), the facility failed to provide supervision, assistance and on-going interventions to reduce resident #1's risk. On 4/9/06 resident #1 sustained a fall resulting in a cervical neck fracture and a head injury at the facility when she was left unsupervised and alone in the bathroom. Resident #1 had diagnoses including dementia, anxiety, ataxia (uncoordinated movement or unsteadiness) and back and neck pain. According to her care plan and documentation in	F 324	Safety Equipment D/C Evaluation Tool has been created to be completed when Safety Equipment has been D/C'd either by family request or by facility recommendation. P&P developed to utilize tool when equipment D/C'd and also in event equipment D/C'd as request of family, but not recommended by facility. DON to monitor compliance as part of RAFT Program. Safety Equipment D/C tool developed to notify DON to initiate Evaluation tool process. Staff training to occur at June meetings (NAR/TMA, Nurses) Training to be completed by June 21, 2006.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-08-06
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 324	<p>Continued From page 1</p> <p>her medical record she was alert and oriented, required the assistance of one staff with her activities of daily living and the assistance of two staff with her mobility needs. She was at risk for falls secondary to a history of several falls at the facility, use of psychotropic medications (which may increase the risk of falls), impaired mobility and a history of unsafe attempts to transfer herself in her room and bathroom without staff assistance. The care plan indicated that a TABs alarm (a device to alert staff when a resident attempts to transfer without assistance) was initiated on 6/28/05 and then it was discontinued on 9/27/05.</p> <p>There was no documentation found indicating why the TABs alarm was discontinued. In addition, no assessments or evaluations were found to determine resident #1's safety after the discontinuation of the TABs alarm. The Nursing Assistant assignment sheets for resident #1 did not identify resident #1 as a fall risk and did not list any interventions to reduce her risk of falls.</p> <p>The facility's incident reports for resident #1 from 6/4/05 through 4/9/06 were reviewed and revealed the following:</p> <p>On 6/4/05 at 6:15 p.m. resident #1 had an unwitnessed fall in her bathroom when she attempted to transfer herself from her wheelchair to the toilet. She missed the toilet and landed on her buttocks. She did not sustain any injuries.</p> <p>On 6/26/05 at 6:05 p.m. resident #1 was found on the floor of her room and stated that she "was trying to get into bed" from her wheelchair. The facility staff initiated a TABs alarm to her wheelchair for safety. She did not sustain any injuries.</p>	F 324		
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F 324	<p>Continued From page 2</p> <p>On 10/3/05 at 7:25 a.m. resident #1 was found between the toilet and her wheelchair in the bathroom. She stated, "I fell off of the toilet ...my feet went numb". She sustained a five-millimeter skin tear to her right forearm. The staff stated that it appeared that the resident "was attempting to self transfer". The incident report's "additional investigative data", completed by employee (H)/administrative staff indicated that resident #1 needed an alarm for her wheelchair. The documentation further indicated that the staff had just removed the TABs alarm "per (resident #1's) request ...as (resident #1) did not make any attempt to self-transfer". The documentation indicated that resident #1 did not want the TABSs alarm and refused the idea of hip protectors. Resident #1 told the staff that her fall was isolated and "she thinks she fell asleep on the toilet".</p> <p>On 12/16/05 at 8:30 p.m. she was found in the bathroom and stated, "(I) was trying to position myself on the toilet and lost my balance, then I fell against my chair".</p> <p>On 4/9/06 beginning at 9:45 a.m. a facility incident report and correlating nursing note completed by employee (C)/nurse and employee (A)/administrative staff, documented that employee (B)/NAR assisted resident #1 to get into the bathroom and advised the resident to use the call light when she finished. Resident #1's wheelchair was in the bathroom to her left. While the resident was in the bathroom, employee (B) went across the hall to make another resident 's bed. When employee (B) finished, she noticed that resident #1's call light was on. Upon entering resident #1's room, she heard a "crash" and entered the bathroom to find resident #1 "on (the) floor, head down, buttocks up in (the) air".</p>	F 324		
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F 324	<p>Continued From page 3</p> <p>She sustained 3" purple bruises to both of her knees, a 3" by 3 1/2" raised hematoma to her forehead and neck pain. The on-call Nurse Practitioner was notified and resident #1 was sent to hospital with emergency services for further evaluation.</p> <p>The hospital records, dated 4/9/06 revealed that resident #1 sustained a C2, non-displaced but complex cervical (neck) fracture, mild acute compression fractures to T3 and T4 (her upper spine) a laceration to her forehead and closed head trauma. Resident #1 indicated to the hospital staff that "her legs fell asleep on the toilet and she tried to get up". She was treated with an external orthosis (a neck brace) and was discharged back to the facility on 4/12/06. She developed pneumonia and expired on 4/29/06.</p> <p>Employee (B)/NAR was interviewed on 5/17/06 at 11:25 a.m. and stated that she was one of resident #1's primary NARs and cared for her two to three times a week. Resident #1 required the assistance of one to two staff (depending on her pain) with transfers, however she did attempt to "self transfer...off of the toilet" approximately once a week. Resident #1 had a TABs alarm last year (unknown date), however, resident #1's family member requested to have the TABs alarm removed. She verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that the policy at the facility is that if a resident has a TABs alarm, the staff can not leave the resident alone in the bathroom, however since resident #1's TABs alarm was discontinued she did not require supervision in the bathroom.</p> <p>Employee (C)/nurse was interviewed on 5/17/06 at 11:45 a.m. and stated the following: she was</p>	F 324		
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F 324	<p>Continued From page 4</p> <p>familiar with resident #1. Resident #1 required the assistance of one staff, however she would transfer herself or "threaten" to transfer herself approximately once a week. If a resident does not have a TABs alarm, there is no need for staff to supervise them in the bathroom. She verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that on 4/9/06 it appeared that resident #1 tried to transfer herself and she fell forward.</p> <p>Employee (A)/administrative staff was interviewed on 5/17/06 at 10:35 a.m. and verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that she did not have a concern regarding the fall because the care plan and policy had been followed. She stated that because resident #1 had attempted to transfer with out staff assistance and a history of falls, a TABs alarm was initiated. However, the family requested that resident #1's TABs alarm be removed because it "agitated" resident #1. She indicated that after resident #1's TABs alarm was discontinued, it was not longer a requirement that the staff supervise her in the bathroom.</p> <p>Employee (H)/administrative staff was interviewed on 5/24/06 at 3:00 p.m. and stated that she was familiar with resident #1. She indicated that resident #1 was "impulsive" and would "intermittently" transfer herself without staff assistance. She stated that resident #1 used to have a TABs alarm and required staff supervision in the bathroom. However during a care conference in September 2005, the TABs alarm was discontinued per resident #1's family request. She indicated that she documented this conversation, but was unable to locate or provide the documentation. She verified that no</p>	F 324		
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F 324	Continued From page 5 assessments or evaluations were done after resident #1's TABs alarm was discontinued to evaluate resident #1's safety. Although resident #1 continued to attempt to transfer herself without staff assistance, the facility staff did not provide any further interventions. She indicated that, according to the facility policy, resident #1 no longer required supervision in the bathroom, because her TABs alarm had been discontinued.
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F 324

Camilia Rose Care Center LLC

11800 Keon Boulevard NW
Coon Rapids, MN 55448-2061
(763) 755-8400

An Equal Opportunity Employer



June 29, 2006

FAX AND U.S. MAIL

Sue Jackson, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East 7th Place, Suite # 300
P.O. Box 64970
St. Paul, Minn. 55164-0970

Re: Addendum to Plan of Correction-Project Number H5353028

Dear Ms. Jackson:

Pursuant to our telephone conference of today, I am submitting the following addendum to our Plan of Correction dated June 8, 2006 relating to the above-stated matter.

F324 Before Safety Equipment is discontinued for a client, there will be a seven-day assessment to identify and memorialize the safety issues. The client and family will be notified of these assessment findings prior to the equipment discontinuation. If the equipment is discontinued, there will be a seven-day assessment subsequent to the discontinuation to determine safety issue outcomes. If the facility has not concurred with the equipment discontinuation, but has honored the client and/or family request, the facility will have staff present in the bathroom for the safety of the client.

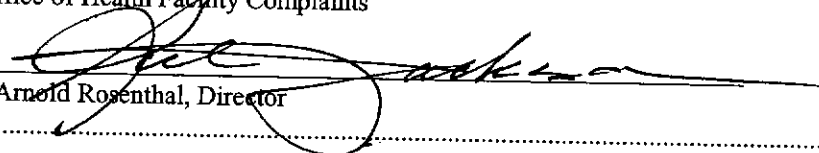
Very truly yours,

A handwritten signature in black ink that reads "Robert J. Rau". The signature is stylized and written over a horizontal line.

Robert J. Rau
Administrator

CERTIFIED MAIL #: 7003 2260 0000 9972 9158

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64970, St. Paul, Minnesota 55164-0970
Office of Health Facility Complaints


Arnold Rosenthal, Director

TO Robert Rau

DATE 5/25/06

PROVIDER Camilia Rose Care Center LLC

COUNTY Anoka

ADDRESS 11800 Xeon Boulevard, Coon Rapids, MN 55448

On 5/25/06 an investigator with the Office of Health Facility Complaints completed a complaint investigation, which began on 05/17/06. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed: _____

Date: _____

In accordance with Minnesota Stat. section 144.653 or Minnesota Stat. section 144A.10, this correction order has been issued pursuant to an inspection (survey)/an inspection (survey) including a complaint investigation./a complaint investigation. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s) listed below, a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Office of Health Facility Complaints within 15 days of receipt of a notice of assessment for non-compliance.

MN Rule 4658.0520 Subpart 1.

Based on interviews and documentation review the facility failed to ensure that supervision, assistance and on-going interventions were provided for one of one resident (resident #1) who was identified to be at risk for falls. Findings include:

Although the facility was aware that resident #1 was at risk for falls due to her unsafe attempts to transfer herself without staff assistance in her room and in her bathroom, history of falls, impaired mobility and psychotropic medication use (which may increase the risk of falls), the facility failed to provide supervision, assistance and on-going interventions to reduce resident #1's risk. On 4/9/06 resident #1 sustained a fall resulting in a cervical neck fracture and a head injury at the facility when she was left unsupervised and alone in the bathroom.

Resident #1 had diagnoses including dementia, anxiety, ataxia (uncoordinated movement or unsteadiness) and back and neck pain. According to her care plan and documentation in her medical record she was alert and oriented, required the assistance of one staff with her activities of daily living and the assistance of two staff with her mobility needs. She was at risk for falls secondary to a history of several falls at the facility, use of psychotropic medications (which may increase the risk of falls), impaired mobility and a history of unsafe attempts to transfer herself in her room and bathroom without staff assistance. The care plan indicated that a TABs alarm (a device to alert staff when a resident attempts to transfer without assistance) was initiated on 6/28/05 and then it was discontinued on 9/27/05.

There was no documentation found indicating why the TABs alarm was discontinued. In addition, no assessments or evaluations were found to determine resident #1's safety after the discontinuation of the TABs alarm. The Nursing Assistant assignment sheets for resident #1 did not identify resident #1 as a fall risk and did not list any interventions to reduce her risk of falls.

Minnesota Department of Health, Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300, P.O. Box 64970, St. Paul, Minnesota 55164-0970

Orders to Camilia Rose Care Center

The facility's incident reports for resident #1 from 6/4/05 through 4/9/06 were reviewed and revealed the following:

On 6/4/05 at 6:15 p.m. resident #1 had an unwitnessed fall in her bathroom when she attempted to transfer herself from her wheelchair to the toilet. She missed the toilet and landed on her buttocks. She did not sustain any injuries.

On 6/26/05 at 6:05 p.m. resident #1 was found on the floor of her room and stated that she "was trying to get into bed" from her wheelchair. The facility staff initiated a TABs alarm to her wheelchair for safety. She did not sustain any injuries.

On 10/3/05 at 7:25 a.m. resident #1 was found between the toilet and her wheelchair in the bathroom. She stated, "I fell off of the toilet ...my feet went numb". She sustained a five-millimeter skin tear to her right forearm. The staff stated that it appeared that the resident "was attempting to self transfer". The incident report's "additional investigative data", completed by employee (H)/administrative staff indicated that resident #1 needed an alarm for her wheelchair. The documentation further indicated that the staff had just removed the TABs alarm "per (resident #1's) request ...as (resident #1) did not make any attempt to self-transfer". The documentation indicated that resident #1 did not want the TABs alarm and refused the idea of hip protectors. Resident #1 told the staff that her fall was isolated and "she thinks she fell asleep on the toilet".

On 12/16/05 at 8:30 p.m. she was found in the bathroom and stated, "(I) was trying to position myself on the toilet and lost my balance, then I fell against my chair".

On 4/9/06 beginning at 9:45 a.m. a facility incident report and correlating nursing note completed by employee (C)/nurse and employee (A)/administrative staff, documented that employee (B)/NAR assisted resident #1 to get into the bathroom and advised the resident to use the call light when she finished. Resident #1's wheelchair was in the bathroom to her left. While the resident was in the bathroom, employee (B) went across the hall to make another resident's bed. When employee (B) finished, she noticed that resident #1's call light was on. Upon entering resident #1's room, she heard a "crash" and entered the bathroom to find resident #1 "on (the) floor, head down, buttocks up in (the) air". She sustained 3" purple bruises to both of her knees, a 3" by 3 1/2" raised hematoma to her forehead and neck pain. The on-call Nurse Practitioner was notified and resident #1 was sent to hospital with emergency services for further evaluation.

The hospital records, dated 4/9/06 revealed that resident #1 sustained a C2, non-displaced but complex cervical (neck) fracture, mild acute compression fractures to T3 and T4 (her upper spine) a laceration to her forehead and closed head trauma. Resident #1 indicated to the hospital staff that "her legs fell asleep on the toilet and she tried to get up". She was treated with an external orthosis (a neck brace) and was discharged back to the facility on 4/12/06. She developed pneumonia and expired on 4/29/06.

Employee (B)/NAR was interviewed on 5/17/06 at 11:25 a.m. and stated that she was one of resident #1's primary NARs and cared for her two to three times a week. Resident #1 required the assistance of one to two staff (depending on her pain) with transfers, however she did attempt to "self transfer...off of the toilet" approximately once a week. Resident #1 had a TABs alarm last year (unknown date), however, resident #1's family member requested to have the TABs alarm removed. She verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that the policy at the facility is that if a resident has a TABs alarm, the staff can not leave the resident alone in the bathroom, however since resident #1's TABs alarm was discontinued she did not require supervision in the bathroom.

Employee (C)/nurse was interviewed on 5/17/06 at 11:45 a.m. and stated the following: she was familiar with resident #1. Resident #1 required the assistance of one staff, however she would transfer herself or "threaten" to transfer herself approximately once a week. If a resident does not have a TABs alarm, there is no need for staff to supervise them in the bathroom. She verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that on 4/9/06 it appeared that resident #1 tried to transfer herself and she fell forward.

Employee (A)/administrative staff was interviewed on 5/17/06 at 10:35 a.m. and verified the information in resident #1's incident report and documentation from 4/9/06. She indicated that she did not have a concern regarding the fall because the care plan and policy had been followed. She stated that because resident #1 had attempted to transfer with out staff assistance and a history of falls, a TABs alarm was initiated. However, the family requested that resident #1's TABs alarm be removed because it "agitated" resident #1. She indicated that after resident #1's TABs alarm was discontinued, it was not longer a requirement that the staff supervise her in the bathroom.

Employee (H)/administrative staff was interviewed on 5/24/06 at 3:00 p.m. and stated that she was familiar with resident #1. She indicated that resident #1 was "impulsive" and would "intermittently" transfer herself without staff assistance. She stated that resident

Minnesota Department of Health, Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300, P.O. Box 64970, St. Paul, Minnesota 55164-0970

Orders to Camilia Rose Care Center

#1 used to have a TABs alarm and required staff supervision in the bathroom. However during a care conference in September 2005, the TABs alarm was discontinued per resident #1's family request. She indicated that she documented this conversation, but was unable to locate or provide the documentation. She verified that no assessments or evaluations were done after resident #1's TABs alarm was discontinued to evaluate resident #1's safety. Although resident #1 continued to attempt to transfer herself without staff assistance, the facility staff did not provide any further interventions. She indicated that, according to the facility policy, resident #1 no longer required supervision in the bathroom, because her TABs alarm had been discontinued.

TO COMPLY: A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and/or designee(s) may review policies and procedures, the DON and/or designee(s) may provide training for facility staff regarding the policies and procedures and the DON and/or designee(s) may complete audits to ensure that the policies and procedures are being followed and to ensure compliance.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

xc: Division of Compliance Monitoring - Licensing & Certification
State and County Departments of Welfare, Attn: Medical Assistance Program

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number: 245353
(Y2) Multiple Construction: A. Building, B. Wing
(Y3) Date of Revisit: 7/6/2006

Name of Facility: CAMILIA ROSE CARE CENTER LLC
Street Address, City, State, Zip Code: 11800 XEON BOULEVARD, COON RAPIDS, MN 55448

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0324	Correction Completed 07/06/2006	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # 483.25(h)(2)		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By: _____ Reviewed By: _____ Date: _____ Signature of Surveyor: _____ Date: _____

State Agency: _____

Reviewed By: _____ Reviewed By: _____ Date: _____ Signature of Surveyor: _____ Date: _____

CMS RO: _____

Followup to Survey Completed on: 5/25/2006

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Camilia Rose Care Center LLC

11800 Xenon Boulevard NW
Coon Rapids, MN 55448-2061
(763) 755-8400

An Equal Opportunity Employer



June 29, 2006

FAX AND U.S. MAIL

Sue Jackson, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East 7th Place, Suite # 300
P.O. Box 64970
St. Paul, Minn. 55164-0970

Re: Addendum to Plan of Correction-Project Number H5353028

Dear Ms. Jackson:

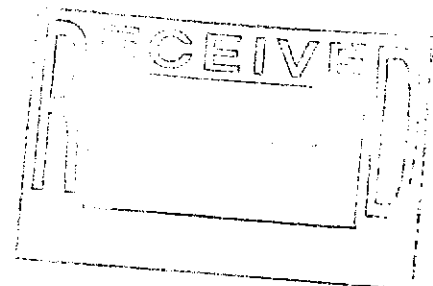
Pursuant to our telephone conference of today, I am submitting the following addendum to our Plan of Correction dated June 8, 2006 relating to the above-stated matter.

F324 Before Safety Equipment is discontinued for a client, there will be a seven-day assessment to identify and memorialize the safety issues. The client and family will be notified of these assessment findings prior to the equipment discontinuation. If the equipment is discontinued, there will be a seven-day assessment subsequent to the discontinuation to determine safety issue outcomes. If the facility has not concurred with the equipment discontinuation, but has honored the client and/or family request, the facility will have staff present in the bathroom for the safety of the client.

Very truly yours,

A handwritten signature in black ink, appearing to read "Robert J. Rau", written over a horizontal line.

Robert J. Rau
Administrator





Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9972 9158

May 26, 2006

Mr. Robert Rau, Administrator
Camilia Rose Care Center Llc
11800 Xeon Boulevard
Coon Rapids, MN 55448

RE: Project Number H5353028

Dear Mr. Rau:

On May 25, 2006, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Camilia Rose Care Center Llc

May 26, 2006

Page 2

months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Sue Jackson, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4210 Fax: (651) 201-4202

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 21, 2006, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 5, 2006 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by

the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred

Camilia Rose Care Center Llc

May 26, 2006

Page 4

between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 25, 2006 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 25, 2006 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

Camilia Rose Care Center Llc

May 26, 2006

Page 5

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

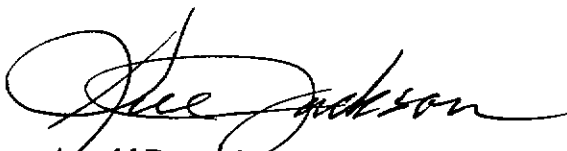
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Arnold Rosenthal, Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 E. 7th Place, Suite #300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 201-4202

Enclosure

cc: Licensing and Certification File

Certified Mail

Certified Mail #: 7003 2260 0000 9972 9158

Facility: Camilia Rose

Project #: H 5353028

Date mailed 5/26/06

Date faxed _____

- Cover letter
- 2567
- Correction orders
- Report
- Assessment letter
- Total notice of assessment
- Subpoena, cover letter and Tennessee

Sent to:

- Complainant
- Facility
- Other

9576 2260 0000 9972 9158

7003 2260 0000 9972 9158

E007

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MDH 85851 7/10/06

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark Here

COON RAPIDS, MN BOX SECTION 1100
 MAY 26 2006
 5032

Sent To: Mr. Robert Rau, Administrator
 Camilia Rose Care Center LLC
 11800 Xeon Boulevard
 Coon Rapids, MN 55448

PS Form 3800, October 2005

Certified Mail

Certified Mail #:

Facility:

Project #: _____

Date sent _____

Date faxed _____

- Cover letter
- 2567
- Correction orders
- Report
- Assessment letter
- Total notice of assessment
- Subpoena, cover letter and Tennessee

Sent to:

- Complainant
- Facility
- Other



Protecting, Maintaining and Improving the Health of Minnesotans

June 29, 2006

Mr. Robert Rau, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

RE: Project Number H5353028

Dear Mr. Rau:

On May 25, 2006, a abbreviated standard survey was completed at your facility. You have alleged that the deficiencies cited on that abbreviated standard survey by the Minnesota Department of Health (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

We will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink, which appears to read "Sue Jackson", is written over the typed name.

Sue Jackson, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4210 Fax: (651) 201-4202

POCA HEALTH

SURVEY.ORG



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1220 5651

July 19, 2006

Mr. Robert Rau, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

RE: Project Number S5353013 and H5353028

Dear Mr. Rau:

On May 26, 2006, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard abbreviated survey, completed on May 25, 2006. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

In addition, on May 30, 2006, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 11, 2006. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 6, 2006, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard abbreviated survey, completed on May 25, 2006 and a standard survey, completed on May 11, 2006. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 21, 2006. Based on our visit, we have determined that your facility has corrected the deficiency issued pursuant to the standard abbreviated survey, completed on May 25, 2006 but has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 11, 2006. The deficiencies not corrected are as follows:

F315 - Urinary Incontinence - 483.25(d)

F432 - Storage Of Drugs And Biologicals - 483.60(e)

In addition, at the time of this revisit, we identified the following deficiency:

F426 - S/S: C - 483.60(a) - Pharmacy Services - Procedures

Camilia Rose Care Center LLC

July 19, 2006

Page 2

The most serious health deficiencies in your facility at the time of the July 6, 2006 revisit were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

In addition, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the May 11, 2006 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 24, 2006. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 11, 2006. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 11, 2006. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 11, 2006. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Camilia Rose Care Center LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 11, 2006. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from the July 6, 2006 revisit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Jeanelle Lahr
Minnesota Department of Health
1645 Energy Park Drive
St. Paul, Minnesota 55108

Telephone: (651)643-2565

Fax: (651)643-2538

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be

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discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 11, 2006 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

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Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Jeanelle Lahr". The signature is written in a cursive, flowing style.

Jeanelle Lahr, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651)643-2565 Fax: (651)643-2538

Enclosure

cc: Licensing and Certification File

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